Legislative Audit Division

State of Montana

Report to the Legislature

November 1997

Limited Scope Review

Medicaid Clinical Laboratory Service Payments

Department of Public Health and Human Services

This report contains recommendations addressing payments to Medicaid providers for clinical laboratory services. The recommendations include developing:

- **Edits to detect potential bundling errors.**
- **Procedures to ensure providers are paid at the correct rate.**
- **Edits to detect potential duplicate payments.**

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November 1997

The Legislative Audit Committee
of the Montana Legislature:

This is our limited scope performance audit of Medicaid Clinical Laboratory Service Payments.

This report contains recommendations concerning developing edits to detect potential bundling errors, procedures to ensure providers are paid at the correct rate, and edits to detect potential duplicate payments. The department's written response to audit recommendations is included in the back of the report.

We thank the director and department personnel for their cooperation and assistance throughout the audit.

Respectfully submitted,

"Signature on File"

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Legislative Audit Division

Limited Scope Review

Medicaid Clinical Laboratory Service Payments

Department of Public Health and Human Services

Members of the audit staff involved in this audit were Kris Wilkinson and Mary Zednick.

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Chapter I - Introduction

Introduction

We performed a limited scope review of controls over clinical laboratory service payments provided through the Montana Medicaid program. The Medicaid program is administered by the Department of Public Health and Human Services (department).

Objectives

The objective of the clinical laboratory services review was to determine the adequacy of procedures and controls over processing Medicaid payments to providers for clinical laboratory tests.

We conducted this review in cooperation with federal auditors who provided technical support under the Medicaid Partnership Plan. The Partnership Plan outlines suggested federal and state joint audits of the Medicaid program which have saved money in other states.

Scope and Methodology

The scope of this review was limited to examining the department's controls over, and procedures followed, for Medicaid clinical laboratory service payments. We sampled payments for urinalysis, hematology and chemistry tests and reviewed payments for any other laboratory services listed on the claims. We did not review all laboratory services nor did we review all expenditures for laboratory services. We did not examine the efficiency of current procedures. Our review was conducted in accordance with applicable government audit standards.

We reviewed 150 provider claims from calendar years 1995 and 1996 to determine if amounts paid to providers were calculated correctly. The federal Office of the Inspector General (OIG) sent us a listing of 50 claims for each type of service. The claims were drawn from information submitted by the department. Federal regulations require certain clinical laboratory tests be grouped together, or bundled, for payment purposes. The OIG drew the claims based on identification of potential overpayments due to certain tests being submitted individually rather than appropriately grouped together (bundling errors). Providers of the services included hospitals providing out-patient services, physicians and independent laboratories. Services are paid based on the fee associated with specific procedure codes listed on claim forms submitted by providers.

We tested each claim form in the samples for specific urinalysis hematology, and chemistry procedures which should have been paid as bundled services. We also ensured other payment requirements were fulfilled, such as: payments to hospitals made at the correct percentage, duplicate payments not made to providers, correct payment methods used, and correct Medicare fee schedules used to calculate payments made by the fiscal intermediary.

Investigation of Possible Fraudulent Billing

During our testing, we noted a pattern of billing in provider claims which suggests the possibility fraud may exist. We referred this matter to the Department of Justice, Medicaid Fraud Unit. The unit is investigating our concerns.

Management Memorandum

During the course of the review we sent a management memorandum to the department. The issue identified is not the subject of recommendations in this report, but can help improve controls over Medicaid clinical laboratory services. The memo addressed exemptions to the clinical laboratory services payment methodology. Federal guidelines require the department to include payment methodology exemptions in the State Plan. The exemptions were included in the federal Health Care Financing Administration (HCFA) guidelines but not specifically listed in the State Plan.

Areas for Future Study

The Montana Medicaid Program expended $323,194,610 and $340,112,114, in fiscal years 1994-95 and 1995-96. Expenditures for clinical laboratory services were approximately $3 million for each year. Payments to providers for all Medicaid services are determined using the Medicaid Management Information System (MMIS). A private firm, known as the fiscal intermediary, operates the system.

The department requests the firm make between 100 and 200 programming changes each year. Changes include implementing new fee schedules and establishing percentages paid to hospitals and nursing homes. Department personnel indicated because of the size of the MMIS (over 3 million lines of programming code) it is not possible to test all consequences of every programming change. During our review of clinical laboratory payments, we found some

changes to payment calculation methods used by MMIS to make provider payments were incorrect. These issues are discussed on page 13 and page 16.

We only reviewed payments for three clinical laboratory tests. We did not review other Medicaid service payments to providers such as nursing home and hospitals. Department staff indicated review of controls over the MMIS is limited. An independent review of general controls was conducted at the fiscal intermediary's head-quarters in 1995; however, the Montana site has not been reviewed in recent years. HCFA will be conducting a recertification review of MMIS during fiscal year 1997-98. This review concentrates on federal reporting requirements. A review of general and application controls is not currently planned. Based on the number of different types of errors identified in this review, and the total amount of yearly benefits paid each year for the Montana Medicaid Program, we believe further study of Montana's Medicaid Management Information System is warranted.

Chapter II - Background

Introduction

The Medicaid program (CFDA # 93.778), administered under federal regulations, serves persons who qualify for financial and medical assistance. This program is administered by the Health Policy and Services Division, the Senior and Long Term Care Services Division, and Addictive and Mental Disorders Division within the Department of Public Health and Human Services (department). The program mission is to ensure Montana's low-income residents have access to medical care.

Medicaid funding includes General Fund, and state and federal Special Revenue Funds. Approximately 70 percent of the expenditures for the Montana Medicaid program are federally funded. The state provides the remaining 30 percent as a match to the federal funds. The state Special Revenue Fund is property tax revenue from the 12 state-assumed counties, nursing home bed taxes and donations. County funds supply part of the state match for primary care Medicaid benefits.

Program expenditures for clinical laboratory services were $3,033,306 in calendar year 1995 and $3,046,963 in calendar year 1996.

Fiscal Intermediary Reimburses Providers for Services

The federal Health Care Financing Administration (HCFA) oversees the Medicaid program and issues guidelines and directives relating to the program. HCFA contracts with states to administer the program. Montana's contract with HCFA, the State Plan, outlines payment methodologies and other program requirements. Federal and state guidelines explain federal matching funds will pay for outpatient clinical laboratory services performed by a physician, independent laboratory, or hospital. Montana's State Plan requires payment for covered lab services under the Montana Medicaid program to be the lessor of the:

-- Providers' usual and customary charge
-- Medicaid fee schedule (department's fee schedule for laboratory service)
-- Medicare fee schedule (National Cap Fee).

Medicaid program payments for clinical lab services cannot exceed the payment recognized by the Medicare program, thus the need for two fee schedules.

The department contracts with a private firm to administer payments to providers of Medicaid services. The private firm (fiscal intermediary) makes payments for clinical laboratory services following the department's directives.

Providers submit claim forms to the fiscal intermediary requesting payment for services provided to Medicaid patients. Personnel of the firm input claims information onto the Medicaid Management Information System (MMIS). Services are listed by procedure code. The information runs through a number of edits which perform data validity functions. The fiscal intermediary pays providers using a fee based on the procedure code.

Section 6300 of the State Medicaid Manual requires the state not pay more than Medicare would pay for services. Medicare regulations regarding payment for clinical laboratory services require certain tests be appropriately grouped together, or bundled, for payment purposes. For clinical laboratory services paid using the Medicare fee schedules, payment for tests submitted individually (unbundled) is greater than payment for bundled services. As a consequence, unbundling of clinical laboratory services results in overpayments.

Laboratory Testing Includes Three Tests

Clinical laboratory testing includes urinalysis, hematology, and chemistry tests. Physicians utilize clinical laboratory tests to assist in diagnosing and treating ailments. The tests may be performed in an independent laboratory, a physician's office or a hospital laboratory as an out-patient service.

Urinalysis Tests

Urinalysis tests involve physical, chemical, or microscopic analysis or examination of urine. They include the measurement of certain components of the sample. A urinalysis may be ordered by the physician as a "complete" test which includes microscopy, a urinalysis without the microscopy, or the microscopy only. Under Medicare guidelines urinalysis tests performed as "complete" are grouped together for payment purposes.

Hematology Tests

Physicians order hematology tests to count and measure blood cells and their content. Blood tests which are grouped and performed on an automated basis are classified as profiles. Automated profiles include hematology component tests such as hemoglobin, red and white blood cell counts, platelet counts, differential white blood cell counts, and a number of other indices. Indices are measurements and ratios calculated from the results of hematology tests. Laboratories calculate indices when performing hematology profiles. Under Medicare guidelines automated profiles performed at the same time are grouped together for payment purposes.

Chemistry Tests

Chemistry tests involve measuring various chemical levels in the blood. Chemistry tests are usually performed on automated equipment. The equipment has the capability to perform between 2 and 22 tests on a single blood specimen. Under Medicare guidelines and the Montana Medicaid Provider Manual for Physician Services dated June 1988, chemistry tests performed at the same time on automated equipment are to be grouped together and paid as a panel. In addition, chemistry tests performed under a single diagnostic classification, such as tests to determine liver disease, are categorized as organ panels. Organ and chemistry panels were developed for coding and payment purposes.

Chapter III - Controls Could Be Improved

Introduction

We reviewed 150 claims for bundling errors. We also determined if the claims were reimbursed using the correct payment method, the current Medicare fee schedule, and the correct hospital designation. We found concerns in each area. The following sections discuss our findings. The findings apply only to clinical laboratory services. We referred concerns about duplicate payments, sole community hospital payments, Medicare fee schedules and correct payment methods to the Legislative Audit Division, Financial-Compliance Audit for further review since these concerns may affect other types of Medicaid payments.

The Office of the Inspector General (OIG) drew the sampled claims based on identification of potential overpayments. OIG identified 6,771 chemistry claims, 3,049 urinalysis claims, and 7,273 hematology claims as potentially containing errors in calendar years 1995 and 1996.

Based on the results of our testing, the OIG projected total overpayments due to bundling errors. The OIG estimates the department overpaid providers $107,552 during calendar years 1995 and 1996 for chemistry, hematology and urinalysis tests which were not submitted with properly bundled procedure codes. Of this amount, approximately $74,996 is the federal share of the overpayments.

Are There Adequate Controls to Ensure Unbundling of Services Does Not Occur?

The audit showed the MMIS does not have edits to detect potential laboratory bundling errors. As a result, the department overpays providers for laboratory services. Our findings for the three laboratory services follow. Tables showing the types of errors found for each claim are on pages 22, 23, and 24.

Urinalysis Errors

We found all 50 urinalysis sample items had errors. Forty-eight of the errors were bundling errors - providers billed as “urinalysis without microscopy” with a separate billing for “microscopy only.” The correct billing should have been urinalysis as a complete test which includes microscopy. Two other errors found in the urinalysis sample were duplicate payment errors. These are discussed in the duplicate payment section.

We also determined the urinalysis sample items contained two claims with chemistry bundling errors and eight claims with hematology bundling errors. These additional errors resulted in overpayments of $73.52 for the ten claims.

Hematology Errors

The 50 hematology sample items had 49 errors. Of these, 47 related to billing of indices in addition to hematology profiles. A separate billing for hematology indices and profiles results in overpayments. This error typically results in an overpayment of $6.38 per claim. We also found duplicate billing of similar services, discussed in the duplicate payments section.

We found three claims with urinalysis bundling errors and two claims with chemistry bundling errors in the hematology sample. These additional errors result in total overpayments for the five claims of $69.85.

Chemistry Errors

Of the 50 chemistry sample items, all 50 contained bundling errors. Thirty-two of the chemistry errors resulted from providers submitting claims for payment of automated battery tests and for additional chemical tests which can be performed on automated equipment simultaneously with the automated battery tests. Under federal guidelines, chemistry tests performed at the same time on automated equipment are to be grouped together and reimbursed as one panel.

The other errors resulted from providers billing chemistry tests separately rather than as a panel. We also found an additional seven claims with hematology bundling errors in the chemistry sample resulting in overpayments of $39.92 for the seven claims.

Overpayments to Providers

The errors in our sample resulted in overpayments to providers of $121.32 for urinalysis bundling errors, $373.30 for hematology and $685.11 for chemistry. Urinalysis bundling errors also resulted in underpayments to providers of $19.09.

The State Plan states payment for clinical laboratory tests under the Medicaid program cannot exceed the amount recognized by the

Medicare program. Medicare requires the payment for separately billed laboratory tests, which are normally available as part of automated battery tests or bundled panels, to be reimbursed based on the lesser amount of the battery panel tests. In addition, Medicaid makes providers liable when payment errors are made due to an overlapping or duplicate billing.

Implementation Costs

In April 1997, we requested the department determine the cost of developing programming to detect bundling errors. In June 1997, the department requested the fiscal intermediary making payments for the Medicaid program estimate the cost of developing programming. As of October 1997, the intermediary had not completed this estimate. Department personnel indicated the fiscal intermediary has a number of programming changes which are higher priority than this request, thus the delay in a response.

Recommendation #1
We recommend the department:

A. Establish edits which detect potential unbundling of clinical laboratory services.

B. Collect the overpayments paid to providers and reimburse the federal portion of the overpayments.

Are There Adequate Controls to Ensure Sole Community Hospital Reimbursements are Made at the Correct Percentage?

The State Plan requires a percentage of the Medicare fee schedule to be used when determining the amount paid to providers for clinical laboratory services. If the provider is a hospital the percentage depends on the federal Health Care Financing Administration's (HCFA) designation of the facility as a sole community hospital. HCFA determines the designation based on factors such as isolated location, weather or travel conditions, or absence of other hospitals in the area. HCFA approves hospitals as sole community hospitals after the hospital applies for this designation through the fiscal intermediary for Medicare. Hospitals designated as sole community are paid 3.23 percent more than hospitals not so designated.

Chapter III - Controls Could Be Improved

Hospitals Incorrectly Reimbursed

The department outlined payment Medicaid methodologies in the State Plan stating sole community hospitals will be paid the lower of the provider's usual and customary charge or 62 percent of the Medicare fee schedule. Non-sole community hospitals payments are made at the lower of the provider's usual and customary fee or 60 percent of the Medicare fee schedule. Federal guidelines state the fee schedule amount of 62 percent is payable only to a qualified hospital laboratory located in a sole community hospital.

During our testing of clinical laboratory services we reviewed the percentages paid to hospitals. Two hospitals in our sample were paid incorrectly. One hospital was paid as a sole community hospital, although HCFA had not designated this facility as such. The other hospital was designated as a sole community hospital, but reimbursed as a non-sole community hospital. This resulted in underpayments of 3.23 percent for Medicaid clinical laboratory services submitted by this hospital during the period.

In reviewing documentation for hospital classifications, we also determined 20 additional hospitals not selected in our sample had been incorrectly paid, one hospital was overpaid and 19 were underpaid. One hospital was approved as a sole community hospital in 1987, sixteen hospital designations changed to sole community hospitals in 1990, one was approved in 1992 and one in 1993. The department, unaware of these changes, continued to pay the hospitals as non-sole community hospitals. All clinical laboratory services paid to these hospitals during this period were underpaid by 3.23 percent.

In 1995, the department requested the fiscal intermediary change the method used to determine sole community status on the MMIS. At the time, the department determined it had been incorrectly paying the hospitals. The department corrected the designations in July 1995 but did not correct the underpayments to the hospitals. We did not determine total incorrect payments for these facilities.

No Procedure to Ensure Determination Updated

The change in status from a non-sole community hospital to a sole community hospital and vice versa occurs infrequently. Neither HCFA nor its fiscal intermediary notifies the department of changes in a hospital's designation. Department personnel stated they believe at one time they assigned someone in the department to contact HCFA's fiscal intermediary every so often to determine if any hospitals had changed status. However, as a result of turnover this task was not done for several years.

Errors Resulted From Programming Change

In July 1995, while making a requested change in the method used to determine sole community hospital designations, the department's fiscal intermediary incorrectly changed the designation of several other hospitals. This resulted in the department overpaying two hospitals and underpaying two other hospitals from July 1995 to July 1996. In July 1996, the department determined this error had occurred and requested the department's fiscal intermediary correct the error. The department did not correct the amounts underpaid or overpaid to the hospitals and did not recover the overpayments to the providers. As a result of these errors during fiscal year 1995-96, the department overpaid the two hospitals $3,313 and underpaid the other two $1,829.

Another error also resulted from the change made in July 1995, discussed above. If a provider performed services before June 30, 1995, and submitted for payment after July 1, 1995, they were paid as a non-sole community hospital regardless of their designation. The error resulted in underpayments to several providers of $903.

Our audit was limited to a review of clinical laboratory services. We did not determine other types of Medicaid services paid using incorrect sole community hospital designations as the basis of payment. Since our audit was limited to clinical laboratory services, we referred our concern that other Medicaid services were incorrectly paid to the Legislative Audit Division Financial-Compliance audit staff currently working at the department.

Recommendation #2
We recommend the department:

A. Develop procedures which ensure hospital designations are correct and updated in a timely manner.

B. Correct underpayments made to providers, recover overpayments to providers and return the federal portion.

Are There Adequate Controls to Ensure Duplicate Payments are Not Made?

As part of our review we tested all requests for clinical laboratory service payments on each claim form to ensure duplicate payments were not made for identical or similar services. We determined 4 of the 150 claims tested had duplicate services submitted and paid. Two of the overpayments related to physician's billing of similar services for hematology. In one case the provider submitted for payment of a blood profile and a component test included in the profile at the same time. The other hematology duplicate billing submitted and paid was for two blood profiles. The profiles included identical components, however one profile included additional components. The other two duplicate payments related to urinalysis services. In one case, the hospital billed for the same service twice on the same day, in the other the physician billed for similar services on the same day. The hospital's duplicate payment was also confirmed by the independent review conducted at the request of the department.

The Montana Medicaid Provider Handbook requires providers return overpayments caused when providers receive duplicate payments. We determined the department overpaid providers $8.04 for duplicate payments discovered in our sample. We did not determine if claims in addition to our sample had duplicate payments submitted and paid.

Duplicate Payment Edits Not Used/Developed For All Claims

We found duplicate payments resulted for two different reasons - type of claim form submitted and lack of procedure code review. Providers submit claim forms to the fiscal intermediary requesting payment for services provided. The type of claim form used is determined by the type of provider performing the service. Physicians and independent laboratories submit requests on a HCFA 1500 form. Hospitals submit requests on a UB-92 form. The edit which checks for duplicate payments on a UB-92 form is not used. As a result, it is possible for hospitals to be paid for duplicate payment requests.

According to fiscal intermediary personnel, edits for duplicate payments on hospital out-patient claims are not run to avoid incorrectly rejecting claims. A hospital can submit for multiple days of services on a claim form. A patient may have the same procedure performed multiple times during length of treatment. As a result, the intermediary personnel believe it is possible the edit would reject a number of correct claims due to listing duplicate procedures performed on multiple days. The rejections would require additional staff time to review, determine the cause of the rejection, and resolve the claim.

Department personnel indicated the correct process for submitting a claim with the same service provided more than once on the same day is to indicate the number of services provided for each procedure code. The system does not consider these duplicate procedures and processes these claims. If the procedures are performed on different dates the system will not reject the claim.

The second reason for duplicate payments is caused by the MMIS. Department personnel indicated certain procedure codes are reviewed for duplication as part of the system's utilization review performed by the MMIS. The system completes this review for all line items within a claim whether submitted by a hospital or a physician. The duplicate codes found in our sample are not included as potential duplicates in the utilization review program edits. As a result, it is possible for providers to be paid for duplicate payment requests.

Chapter III - Controls Could Be Improved

Recommendation #3

We recommend the department help ensure duplicate payments are not made for clinical laboratory services by increasing the procedure codes reviewed to detect duplicate payment requests submitted by providers.

Are There Adequate Controls to Ensure the Correct Payment Method is Used?

The department outlines methodologies for payments to providers in the State Plan, a contract detailing the state's agreement with HCFA. The department is required to comply with the procedures it outlines in the State Plan. July 1, 1995, the plan was amended to read payments for hospitals providing out-patient clinical laboratory services will be paid on a fee basis of the:

-- Lower of the provider's usual and customary charge, or
-- Applicable percentage of the Medicare fee schedule.

For clinical diagnostic laboratory services where no Medicare fee is assigned, the fee is determined based on a percentage of the hospital's usual and customary charge. Prior to July 1995, the Medicaid fee schedule was also considered in the hospital payment methodology.

Payments for Services Not Correct

We reviewed the claims to ensure laboratory service payment amounts were calculated using the correct payment method. For clinical laboratory services, we found payment calculations for 17 procedure codes were based on Medicaid fees. Paying hospitals for out-patient services using Medicaid fees was eliminated from the State Plan July 1, 1995. Payments for the procedure codes were paid at the wrong rate from that date to at least June 1997. The department requested the fiscal intermediary correct the coding after we informed them of the problem in May 1997.

Error Result of Programming Changes

The department implemented the payment methodology discussed above beginning July 1, 1995, by requesting the fiscal intermediary change the computer fee schedules for hospital out-patient clinical laboratory services. The intermediary changed the fee schedules for the majority of the procedure codes relating to clinical laboratory services. However, in instances with no Medicare fee assigned, the intermediary made payments based on the Medicaid fee instead of changing to a percentage of the provider's usual and customary charge as required in the State Plan. Personnel in the Medicaid Services Bureau indicated they did not ensure all changes made by the fiscal intermediary were correctly completed.

We determined hospital payments for the 17 laboratory procedure codes totaled $37,926 from July 1, 1995 through December 31, 1996. Payment should have been based on a percentage of the provider's usual and customary charge, which varies from provider to provider. The department determined they underpaid some providers $6,736 and overpaid other providers $629.

Department Could Use Existing Resource to Review Changes

The department is responsible for ensuring changes made to the MMIS are correctly implemented by the fiscal intermediary. One option for the department would be using personnel from the Surveillance Utilization and Review Section (SURS) of the Quality Assurance Division to assist in reviewing some changes to the MMIS. This section completes retrospective reviews of various Medicaid programs. Staff are trained in Medicaid regulations and use the MMIS to complete reviews of Medicaid programs. The scope of the SURS reviews could be expanded to include system changes to provider payment calculations.

Recommendation #4

We recommend the department develop procedures to ensure changes to payment methodologies for clinical laboratory services are complete, correct and implemented in a timely manner.

Chapter III - Controls Could Be Improved

Are There Controls to Ensure the Correct Medicare Fee Schedules are Used?

HCFA issues a new Medicare fee schedule yearly. HCFA personnel indicated the schedule is sent each December. The department uses the fee schedule to make payment calculations on claims submitted for services performed between January 1 and December 31 each year. Each year the department requests the fiscal intermediary load the new fee schedules onto the MMIS. In order to use the new schedules for payment calculations the schedule should be loaded onto MMIS prior to January 1 each year. In 1995, the department requested the firm load the new fee schedule January 17th. The upload was not completed until March 27, 1995. Until the update occurred all claims submitted for services performed after January 1 were paid using the previous year's Medicare fee schedule. In 1996 the schedules were not loaded onto the computer system until May 22, 1996. Again, claims submitted for services performed after January 1, 1996, were paid using the previous year's Medicare fee schedule until the update occurred.

The department's contract with the HCFA outlines the payment methodologies for reimbursement of clinical laboratory services. The contact states clinical laboratory services will be reimbursed using the prevailing Medicare fee schedule.

Providers Incorrectly Paid

We found 36 (24 percent) of the 150 claims in our sample were paid using the previous year's Medicare fee schedule. Between January and May of 1996 the department overpaid providers a total of $14,350 for clinical laboratory services due to the use of the previous year's Medicare schedule. Between January and March of 1995, the department overpaid a total of $13,289 in clinical laboratory services. In most cases, the Medicare fee schedules for calendar years 1995 and 1996 were lower than the previous year; however, we also found some payment amounts for various procedures were higher in the following year. As a result, we found providers were underpaid $4,403 and $1,273 respectively, during the period.

The fiscal intermediary changes MMIS at the request of the department. Department personnel indicated they prioritize this request along with other programming changes. The department does not have procedures in place to confirm the Medicare fee schedule has

been loaded onto the system in a timely manner. The department did not determine the reason for the delay in 1995. They also did not collect the overpayments paid to providers. In 1996, the department did not attempt to locate the schedules until May, five months after they should have begun using the fee schedule for reimbursements.

Recommendation #5
We recommend the department:

A. Develop procedures which ensure the Medicare fee schedules are uploaded onto MMIS before January 1 of each year.

B. Correct underpayments made to providers, recover overpayments, and return the federal portion.

Medical Reviews Lack Guidelines

In April, after we completed testing clinical laboratory service claims, the department requested 12 providers submit medical records for 43 claims tested in our sample. The department staff stated they wanted to ensure providers did not have a medical reason for the coding submitted on the claims.

The department received medical records for 30 claims. Providers failed to submit records, submitted records for the wrong date or failed to provide physician's orders for laboratory tests for the remaining 13 claims. A coding specialist on contract with the department reviewed the records. The coding specialist confirmed the Medicaid bundling errors we found for the 30 claims reviewed. The specialist also found 6 claims with 12 procedure codes which were not ordered by the physician. Providers were paid $225.03 for these procedures. In addition, from the information on the medical records, the reviewer found another eight coding errors.

The department also has a contract with a private firm to provide assistance with provider claims. Services provided by the firm include reviewing claims to determine medical necessity of treatment, correct procedure codes, and appropriateness of preauthorizations. In June, the department requested the private

firm obtain the medical records from providers who had not submitted records when requested. In addition, the private firm reviewed those records reviewed by the coding specialist.

In some instances, the two reviewers did not reach the same conclusion as to whether services codes were incorrectly billed. Of the 30 claims reviewed by both reviewers, results differed on 20 claims.

Department staff stated they did not provide guidelines to the contractors performing the reviews. They rely on the expertise of the contractors to determine provider claim errors. It appears the private contractor and coding specialist reviewing claims may not be using the same criteria when evaluating coding. The use of different criteria may result in providers receiving different payment amounts for providing the same services.

Recommendation #6
We recommend the department:

A. Provide appropriate guidelines to code reviewers.

B. Evaluate claim reviews to ensure federal guidelines are followed.

Summary

We found the department does not have adequate controls to ensure correct payments are made to providers for clinical laboratory services. We found numerous bundling errors and numerous types of payments errors. Many of the claims had multiple errors. Tables 1, 2 and 3 show the types of errors found in each sample and the numbers of errors found per claim form. Because the claims were drawn to review potential bundling errors, we anticipated a high number of errors for bundling. We did not anticipate any other types of errors would be found in our sample.

A number of the errors found in the sample were due to the work of the fiscal intermediary. The department is responsible for monitoring the performance of its fiscal intermediary. We found the department's role in monitoring the fiscal intermediary could be

strengthened. We believe additional requirements should be included in the contract with the fiscal intermediary which specifically define the intermediary's responsibilities under the contract.

We only examined controls over clinical laboratory services which have yearly expenditures of approximately $3 million. Total yearly Medicaid expenditures are approximately $340 million. Due to the number and types of errors found in our laboratory services sample, the total cost of Medicaid expenditures processed using MMIS, and the additional examples of concerns with other types of Medicaid payments, we believe further study of the MMIS is warranted.

Table 1
Errors Per Urinalysis Claim Form

Claim #	Type of Provider	Urinalysis Bundling Error	Chemistry Bundling Error	Hematology Bundling Error	Hospital fee calculated using Medicaid fee schedule	Duplicate Payment	Fee Calculated Using Previous Year's Medicare Schedule	Hospital Paid at wrong rate	Organ Panel Errors
1-1	Phy	x							
1-2	Hos	x			x				
1-3	Phy	x							
1-4	Hos	x		x	x				
1-5	Phy	x							
1-6	Phy	x							
1-7	Hos	x			x				
1-8	Phy	x							
1-9	Phy	x							
1-10	Hos	x			x	x			
1-11	Phy	x		x					
1-12	Phy	x							
1-13	Phy	x							
1-14	Phy	x							
1-15	Phy	x							
1-16	Phy	x							
1-17	Hos	x		x	x		x		
1-18	Phy	x							
1-19	Phy	x				x			
1-20	Hos	x		x	x				
1-21	Phy	x							
1-22	Phy	x							
1-23	Phy	x							
1-24	Phy	x							
1-25	Hos	x			x				
1-26	Hos	x		x	x		x		
1-27	Phy	x							
1-28	Hos	x			x			x	
1-29	Phy	x							
1-30	Phy	x	x				x		
1-31	Phy	x							
1-32	Hos	x			x			x	
1-33	Phy	x							
1-34	Phy	x							
1-35	Phy	x							
1-36	Hos	x			x				
1-37	Phy	x							
1-38	Phy	x							
1-39	Hos	x		x	x				
1-40	Phy	x							
1-41	Phy	x							
1-42	Hos	x			x				
1-43	Phy	x							
1-44	Phy	x							
1-45	Phy	x							
1-46	Phy	x							
1-47	Hos	x	x	x	x		x		
1-48	Phy	x							
1-49	Phy	x							
1-50	Hos	x					x		
Total Urinalysis	Hos - 15 Phy - 35	50	2	7	14	2	5	2	0

Table 2
Errors Per Hematology Claim Form

Claim #	Type of Provider	Urinalysis Bundling Error	Chemistry Bundling Error	Hematology Bundling Error	Hospital fee calculated using Medicaid fee schedule	Duplicate Payment	Fee Calculated Using Previous Year's Medicare Schedule	Hospital Paid at wrong rate	Organ Panel Errors
2-1	Hos			x					
2-2	Hos			x					
2-3	Hos			x					
2-4	Phy			x					
2-5	Hos		x	x	x		x		
2-6	Hos			x					
2-7	Hos			x					
2-8	Hos			x					
2-9	Phy			x					
2-10	Hos	x		x	x		x		
2-11	Phy			x					
2-12	Hos			x			x		
2-13	Hos			x			x		
2-14	Phy			x		x			
2-15	Phy			x		x			
2-16	Hos			x			x		
2-17	Phy			x					
2-18	Hos			x					
2-19	Hos			x					
2-20	Hos			x					
2-21	Phy			x					
2-22	Phy								
2-23	Hos			x			x		
2-24	Phy			x					
2-25	Phy			x					
2-26	Hos			x					
2-27	Hos			x					
2-28	Hos			x			x		
2-29	Hos	x		x	x		x		
2-30	Hos			x					
2-31	Hos			x			x		
2-32	Hos			x			x		
2-33	Hos			x					
2-34	Hos		x	x					
2-35	Hos			x			x		
2-36	Phy			x					
2-37	Hos			x			x		
2-38	Phy			x					
2-39	Hos			x					
2-40	Hos			x					
2-41	Phy			x					
2-42	Hos			x					
2-43	Hos			x					
2-44	Hos			x			x		
2-45	Phy			x					
2-46	Hos			x			x		
2-47	Hos			x	x				
2-48	Hos	x		x	x		x		
2-49	Hos			x					
2-50	Hos			x					
Total Hematology	Hos - 36 Phy - 14	3	2	49	5	2	15	0	0

Table 3
Errors Per Chemistry Claim Form

Claim #	Type of Provider	Urinalysis Bundling Error	Chemistry Bundling Error	Hematology Bundling Error	Hospital fee calculated using Medicaid fee schedule	Duplicate Payment	Fee Calculated Using Previous Year's Medicare Schedule	Hospital Paid at wrong rate	Organ Panel Errors
3-1	Hos		x	x			x		
3-2	Hos		x						x
3-3	Phy		x						
3-4	Phy		x				x		
3-5	Phy		x				x		
3-6	Hos		x	x			x		
3-7	Hos		x				x		
3-8	Hos		x				x		
3-9	Lab		x						
3-10	Lab		x						
3-11	Hos		x					x	
3-12	Lab		x				x		
3-13	Phy		x						
3-14	Lab		x						
3-15	Lab		x						
3-16	Hos		x	x			x		
3-17	Hos		x						
3-18	Phy		x						
3-19	Phy		x						
3-20	Phy		x						
3-21	Hos		x						
3-22	Phy		x						
3-23	Phy		x						
3-24	Hos		x						
3-25	Hos		x						
3-26	Hos		x	x					
3-27	Hos		x				x		
3-28	Hos		x				x		
3-29	Hos		x						
3-30	Hos		x						
3-31	Hos		x				x		
3-32	Phy		x						
3-33	Hos		x						
3-34	Hos		x						x
3-35	Phy		x						
3-36	Lab		x						
3-37	Hos		x	x	x				
3-38	Phy		x						
3-39	Hos		x				x		
3-40	Hos		x				x		
3-41	Phy		x						
3-42	Hos		x	x			x		
3-43	Lab		x						
3-44	Hos		x				x		
3-45	Hos		x						
3-46	Hos		x						
3-47	Hos		x						
3-48	Hos		x	x			x		
3-49	Hos		x			x	x		
3-50	Hos		x						
Total Chemistry	Hos - 30 Phy - 13 Lab - 7	0	50	7	1	1	17	1	2

Agency Response

DEPARTMENT OF
PUBLIC HEALTH AND HUMAN SERVICES
HEALTH POLICY & SERVICES DIVISION

MARC RACICOT
GOVERNOR

LAURIE EKANGER
DIRECTOR

STATE OF MONTANA

COGSWELL BLDG., 1400 BROADWAY
PO BOX 202951
HELENA, MONTANA 59620-2951

October 22, 1997

Jim Pellegrini, Deputy Legislative Auditor
Legislative Audit Division
Room 135, State Capitol Building
PO Box 201705
Helena, Montana 59620-1705

Dear Mr. Pellegrini:

Attached are written responses prepared by the Department of Public Health and Human Services regarding audit recommendations resulting from the Medicaid Clinical Laboratory Service Payments audit.

Please contact Jeff Ireland of the Health Policy and Services Division at 444-4146 if you have questions regarding these responses.

Sincerely,

Laurie Ekanger
Director

cc Nancy Ellery, Administrator
Mary Dalton, Chief
John Chappuis, Chief
Jeff Ireland, Supervisor
Terry Krantz, Supervisor
Dave Thorsen, Supervisor
Jeff Buska, Program Officer
Randy Bowsher, Program Officer
Michelle Gillespie, Program Specialist

PHONE: (406) 444-4540 FAX: (406) 444-1861

RECOMMENDATION #1

We recommend the department:

A. Establish edits which detect potential unbundling of clinical laboratory services.

B. Collect the overpayments paid to providers and reimburse the federal portion of the overpayments

Department response: We agree that establishing edits can and should be performed when specific criteria can be programmed to detect and prevent unbundling without denying appropriately billed services. When the nature of circumstances is variable, edits become an ineffective means to control processing and other means must be evaluated to determine the feasibility of preventing and correcting inappropriate billing, including but not limited to retrospective review, and education.

Certain specific instances lend themselves very well to prepayment edits such as the cited example of urinalysis without microscopy billed with an additional charge for the microscopy only. The only instance where it would be appropriate to bill for both would be if a urinalysis without microscopy were ordered and at a later time in the day a microscopy only was ordered. The Department believes the rarity of this exception allows for an edit to be placed in the system.

In other areas such as hematology and chemistry, the circumstances are much more variable. Both the Current Procedural Coding (CPT) structure and the Healthcare Common Procedural Coding System (HCPCS) contain codes allowing the designation of chemistry test panels performed on automated multichannel equipment, for manual testing, and for individual tests performed on an immediate (stat) basis. It is not uncommon for a patient to receive a panel test and have additional tests ordered the same day on a "stat" basis. The claim form will not contain sufficient information to determine if these tests were performed together as a panel and should be bundled and these circumstances preclude the effective implementation of an edit to prevent unbundling. Without manual review of the documentation of the physician order for the test, which is maintained at the providers place of business, it is impossible to determine the appropriateness of the billing with any certainty. In instances such as these it seems more efficient to identify areas where inappropriate activity is concentrated, and strengthen the internal controls through provider education, retrospective review and audit. These processes are more resource intensive and evaluation of the cost effectiveness of these actions is needed before action is taken.

The Department agrees to continue to establish edits when appropriate edits can be implemented without causing inappropriate denial. We will also review the feasibility of retrospective review of providers who routinely unbundle claims. In order to avoid duplication of work performed by the Office of the Inspector General (OIG), we would ask that the samples drawn by the OIG identifying suspected errors be released to the department to be used as a basis for selecting providers to be reviewed. This method will identify specific providers and the billing routines that fall outside standards for billing lab services, allow for collection of overpayments if feasible, target providers in need of education, and will provide a sentinel effect to prevent future inappropriate billings. The federal share of all overpayments collected will be reimbursed to the Health Care Financing Administration.

RECOMMENDATION #2

We recommend the department:

A. Develop procedures which ensure hospital designations are correct and updated in a timely manner.

Department response: The department agrees with the recommendation by the Legislative Audit Division. Department staff recognize the importance of keeping the claims payment system (MMIS) updated and current in order to properly reimburse health care providers. As noted in the audit report the change in status from a non-sole community hospital to a sole community hospital (SCH) and vice versa occurs infrequently. The department will contact the Medicare intermediary on an annual basis to verify our list of sole community hospitals to that of Medicare. This will occur during our annual update of the payment methodology for services provided on or after July 1 of the state fiscal year. In addition, we will notify hospitals that in order to take advantage of the additional reimbursement granted to a sole community hospital at a time other than July 1 of the rate year, the hospital must notify the department in writing of the change and effective date of the sole community hospital status. The SCH rate change will be effective upon notification of the department or July 1 of the rate year. The department will not retroactively adjust claims for SCH status established before July 1 of a rate year.

B. Correct under payments made to providers, recover overpayments to providers and return the federal portion.

Department response: The department agrees with the recommendation by the Legislative Audit Division regarding the SCH payment errors for the two hospitals which were overpaid and the two hospitals that were underpaid due to the incorrect designation of the SCH indicator. In addition, we agree with the recommendation with regard to the payment errors resulting from the programming change and claims with dates of service prior to July 1, 1995 and paid after July 1, 1995. The department will determine the scope of the payment errors for each facility and consider the cost benefit of making the appropriate adjustment to increase or decrease the providers payment based upon the audit findings.

The department has summarized these issues as well as the payment error regarding the 17 laboratory procedure codes and would like to note that approximately 83% of the facilities involved in the laboratory payment errors have less than a $100 impact on their reimbursement. Some of the payment errors are as low as 4 cents payable to a facility and conversely one facility owes the department 39 cents. We do not think it is cost beneficial to issue a warrant or recover such small amounts from providers. In addition, please note that the department is still working on a report with the fiscal intermediary to determine the scope of the payment error with the four facilities paid with the incorrect SCH indicator. Upon receipt of all this information the department will make a determination in order to correct under payments made to providers and recover overpayments to providers.

The department does not agree with the underpayment determination for the 20 hospitals as noted on page 12 of the audit report. The laboratory SCH and Non-SCH payment methodology was implemented by the State in 1987/1988. At that time the department had a list of hospitals

with the SCH designation that was hard coded into the claims processing system. Between 1989 and 1994 approximately 20 hospitals were granted the SCH designation by Medicare. We became aware of the SCH designation for these facilities in the spring of 1995 when we were modifying our reimbursement methodology for state fiscal year 1996. We did not determine that we had been paying the hospitals incorrectly during 1989 through 1995 because we did not know these hospitals were sole community providers. The hospitals never notified the department of their SCH status for the additional reimbursement allowance. Upon finding out their SCH status the department added this indicator for each facility effective 7/1/95. The department believes these providers were reimbursed correctly during this time. Based upon the information we had during that time period the providers were paid appropriately in accordance with our administrative rules and state plan. Therefore, the department does not believe it should be required to correct the alleged underpayment as noted by the legislative auditor.

RECOMMENDATION # 3
We recommend the department help ensure duplicate payments are not made for clinical laboratory services by increasing the procedure codes reviewed to detect duplicate payment requests submitted by providers.

Department response: The department does not agree that increasing the review of procedure codes is an effective way to reduce duplicate payments for clinical lab services. The addition of procedure codes that are potential duplicates to the systems utilization review process requires, additional programming and increases staff resources manually review these potential duplicates.

In order to utilize limited staff resources in the most efficient manner, the department uses several review methods to identify and prevent material duplicate payments. First the department utilizes the Claims Processing Assessment System (CPAS) to select random claims on a routine basis to insure payment accuracy. The randomness of this activity is useful to insure that any one part of the payment process is not overlooked. Claims selected in this limited sample are extensively reviewed for duplication, appropriate pricing, and adherence to payment procedures. In addition concentrated reviews can identify specific providers and procedures that may require additional control to insure appropriate billing. These controls are evaluated to determine if an appropriate means can be implemented, the impact on the system and the provider and for overall effectiveness. These controls can be in a variety of forms including system edits, provider and recipient prepayment and postpayment reviews, etc. Should situations be identified that result in overpayments or potential fraud or abuse, they are referred to the Medicaid Review Committee and/or the Medicaid Fraud Unit for action.

This progressive and concentrated effort results in a systematic method to identify and correct material errors and prevent overpayments in an efficient and appropriate manner. While prevention of duplicates is a division goal, it should be approached in a method that considers the magnitude of the problem and the efficiency of the method used to resolve it. The department does not feel that some of the items identified justify the resources necessary to implement the recommendation.

RECOMMENDATION #4

We recommend the department develop procedures to ensure changes to payment methodologies for clinical laboratory services are complete, correct and implemented in a timely manner.

Department response: The department disagrees with this recommendation as current procedures already exist to ensure that changes to the MMIS are timely and accurately implemented. System enhancements cannot be implemented without written approval from the Department. The approval is accompanied by an assurance that the enhancement was tested for functionality. Any problems identified during testing are noted and immediately corrected.

The system enhancement is tested for its functionality. It is in no way tested for every scenario that can possibly occur. Therefore, it is possible that an error could occur at a future date that was caused by something not identified during the testing process. In these instances, the department corrects error as quickly and efficiently as possible and evaluates the fiscal impact of correcting related claim errors.

The department continually evaluates its enhancement approval and testing processes to identify areas that would result in an increased probability that potential conflicts are identified before enhancements are implemented.

RECOMMENDATION #5
We recommend the department:

A. Develop procedures which ensure the Medicare fee schedules are uploaded onto MMIS before January 1st of each year.

B. Correct under payments made to providers, recover overpayments, and return the federal portion.

Department response:
A. The Department concurs with the recommendation made by the Legislative Auditor to ensure that Medicare fee schedules are timely and accurately uploaded onto MMIS. The department has established policy to address this issue.

B. The Department agrees that lab overpayments and under payments to providers caused by delayed Medicare lab fee tapes should be evaluated but not necessarily corrected in all instances for the following reasons:

1. The Department considers lab fee updates to become effective on the date that they are implemented. This policy supports consistent provider treatment.

2. The Department has determined that correcting overpayments and under payments caused by tardy lab fee updates would not be cost effective.

RECOMMENDATION #6
We recommend the department:

A. Provide appropriate guidelines to code reviewers.

Department response: The department responded to this area of concern in a letter dated September 30, 1997 to Mary Zednick, Performance Audit Manager. We have attached a copy of that response for your reference.

B. Evaluate claim reviews to ensure federal guidelines are followed.

Department response: The department does provide information to all contractors when federal rules and regulations are adopted by the Medicaid program for coverage, coding, and utilization review services. Department staff review and discuss the contractors findings as deemed appropriate. Please note that the department usually contracts for these services because department staff do not possess the professional expertise to perform these services. Unless otherwise directed by the department, the department relies on the professional expertise of the contractor for the services provided.

ADDITIONAL COMMENTS

The department recognizes that controls are essential to insure proper and appropriate reimbursement for services . Over the last decade the department has continually modified the Medicaid Management Information System to implement effective controls and create a system that processes claims efficiently. This has resulted in the implementation of hundreds of system edits, volumes of manual instructions and procedures and a continuous stream of requests to improve the system.

The department also recognizes that limited scope reviews can be very useful in identifying areas that need to be strengthened. One of the difficulties encountered in a limited scope review is that many of these controls are not recognized and the complex nature of the system cannot be reflected in the review. Oversimplification in the review may lead to the conclusion that recommendations are easily implemented and will have no detrimental impact on system operation, staff resources or the providers or clients. All new edits and procedures must be evaluated for the inappropriate payments that they prevent versus the resources that are used to implement them (by both the provider and the payer of the service).

One area in the review that we feel needs further clarification is the relationship between Medicare and Medicaid regarding laboratory reimbursement. Section 6300 of the State Medicaid Manual provides the guidance from HCFA to state medicaid agencies on limitations for payment for lab services. It states that Medicaid matching funds are not available to the extent that the state pays more for an outpatient clinical lab test performed by a physician, independent lab, or a hospital than the amount medicare recognizes for such tests. If a Medicare fee has not been established no such limitation applies.

To examine whether Montana Medicaid meets this test, the department examines individual fees as well as expenditures in the aggregate. In many cases, Medicaid payment for lab services is much lower that Medicare because of lower Medicaid fee schedules. The department is confident that it meets the HCFA Medicaid guidelines.

The manual also states that these guidelines are designed to provide assistance to the State in implementing, where applicable, the limitations of the Medicare fee schedule, that the impact of the Medicare regulations on the Medicaid program is strictly with respect to the amount of payment, and that the applicable Medicare assignment and billing requirements are not necessarily to be incorporated into the State Medicaid program.

The department feels that the report generalizes many Medicare regulations, methods and guidelines as federal requirements that Medicaid must follow. This is not the case and the department feels that this needs to be recognized.

DEPARTMENT OF
PUBLIC HEALTH AND HUMAN SERVICES
HEALTH POLICY & SERVICES DIVISION

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STATE OF MONTANA

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September 30, 1997

Mary Zednick
Performance Audit Manager
Legislative Audit Division
Room 135, State Capitol Building
PO Box 201705
Helena, MT 59620-1705

Subject: Laboratory Audit - Response to the 9/17/97 letter.

Dear Mary:

This letter and attachment is in response to your letter dated September 17, 1997 regarding issues related to the performance audit of Clinical Laboratory Service reimbursements. I apologize for the delay in responding to your letter.

If you have any questions regarding the attached responses, please contact Jeff Ireland or Dave Thorsen. Thank You.

Sincerely,

Nancy

Nancy Ellery, Administrator
Health Policy and Services Division

attachment

c Mary Dalton
John Chappuis
Jeff Ireland
Dave Thorsen
Randy Bowsher
Jeff Buska
Michelle Gillespie

DPHHS/HPSD Responses to: Legislative Audit Division
Interim Audit Communication
Dated September 17, 1997

Clinical Laboratory Service Claims

Recommendation: We recommend the department establish criteria on federal guidelines for claims review which ensure identical results regardless of the reviewer.

Response: The Department of Public Health and Human Services, Health Policy and Services Division does not agree with the recommendation to establish criteria on federal guidelines for claims review which ensure identical results regardless of the reviewer.

Medical practice is an art as much as it is a science. The treatment practice necessary for one patient is not always identical to the treatment required for another patient even though treatment may be for the same diagnosis. This results from individual differences in the patient and individual differences in the attending physician's determination on how to best treat the diagnosis.

The coding on a claim for the medical services provided by a physician and health care facility is based upon the documentation contained in the medical record, and the coders interpretation of that documentation. Coders, like other professionals, are responsible to conduct their business in accordance with professional guidelines. Generally this includes a code of ethics, as well as following the coding conventions contained in the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) manual, the American Hospital Association (AHA) Coding Clinic for ICD-9-CM, the Physician's Current Procedural Terminology (CPT), and the Health Care Financing Administration's Common Procedure Coding System (HCPCS). These manuals provide the general basis for the profession on coding medical claims.

In addition to these coding requirements the various health care payers have their own billing requirements for health care services based upon the services that are covered by the payor. Medicare, for example utilizes various manuals to define their coverage of services and billing requirements. One of which, the Medicare Carriers Manual HCFA Pub 14-3, is identified in your memo. Medicaid on the other hand utilizes our Administrative Rules of Montana, State Plan, and program manuals to define coverage of services and billing requirements.

The Medicaid program is not exactly the same as the Medicare program for coverage of services and billing requirements. However, the Medicaid program tries to follow Medicare for coverage of services and billing requirements where practical and appropriate. When this is done a reference to the Medicare rules and regulations is incorporated by reference in the Administrative Rules of Montana. Please note that the Medicare Carriers Manual is not referenced in the Administrative Rules of Montana for billing laboratory services for the Medicaid program. The Medicaid program utilizes the State Medicaid Manual HCFA Pub. 45 in our references regarding laboratory services. The Medicaid program does not have specific billing instructions for billing laboratory services other than those outlined in the appropriate coding manuals. Under the

Medicare Carriers Manual, Medicare has made a determination that there is no difference between the manual and automated tests. Under the HCFA Common procedural coding system there still is the distinction between manual and automated testing. It is apparent that the legislative auditor believes the Department must follow this Medicare criteria for coding and payment. While it may be reasonable for the Department to do this, we have not incorporated the Medicare Carriers Manual HCFA Pub 14-3, by reference for coding and billing Medicaid laboratory services. The Department will consider the cost benefit of incorporating the Medicare coding and billing requirements for laboratory services for the Medicaid program.

When the Department contracts with a coding specialist or peer review organization we notify the contractor of the Administrative Rules and the applicable Medicare requirements. Otherwise the Department relies on the contractor's professional experience to conduct the review in accordance with industry guidelines and protocols. The department contracts with independent contractors for various services such as claim coding review and utilization review services because we do not have the technical expertise in house for these services. The Department relies on the professional expertise of these contractors for the requested services. Generally these contractors will arrive at similar results when reviewing the same material, and other times they may have different opinions.

The two reviewers did come to different opinions regarding the coding on the sample claims. In this instance the review was performed progressively with the initial review performed by the coding specialist, which confirmed the issue raised by the auditor using Medicare coding criteria. The follow-up review by the private contractor was not predicated by the Medicare criteria to review the specific circumstances, and they came up with a different opinion, based upon the appropriate coding guidelines.

Utilization of review criteria based upon federal guidelines will not ensure identical results regardless of the review activity. It would however assist the reviewer on the criteria upon which to base the review, but it would not assure identical results. The education, judgement, and experience of the reviewer also play an integral part in the results of the review. This is often true of other areas of professional expertise including auditing, where education, judgement, and experience play an integral role in the design, procedures, and outcomes of an audit.